		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032961

Facility Name: SPRINGFIELD TERRACE

Address: 525 S. MARTIN LUTHER KING DR. (Number) SPRINGFIELD (City) 62703 (Zip Code)

County: SANGAMON

Telephone Number: (217) 789-1680 **Fax #** (217) 789-0842

IDPA ID Number: 37-1223350001

Date of Initial License for Current Owners: 11/06/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MELVIN SIEGEL
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,725	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,725	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	17,766	1,161		18,927	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,766	1,161		18,927	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.78%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/06/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/06/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	81,581	3,623	3,680	88,884		88,884		88,884			1
2	Food Purchase		73,638		73,638		73,638	(522)	73,116			2
3	Housekeeping	42,548	9,438		51,986		51,986		51,986			3
4	Laundry	22,240	5,264		27,504		27,504		27,504			4
5	Heat and Other Utilities			34,795	34,795		34,795	1,273	36,068			5
6	Maintenance	16,990	17,653	15,666	50,309		50,309	(2,515)	47,794			6
7	Other (specify):*			6,436	6,436		6,436	67	6,503			7
8	**TOTAL General Services**	163,359	109,616	60,577	333,552		333,552	(1,697)	331,855			8
	B. Health Care and Programs											
9	Medical Director			14,500	14,500		14,500		14,500			9
10	Nursing and Medical Records	460,659	13,213	4,955	478,827		478,827	7,161	485,988			10
10a	Therapy			781	781		781		781			10a
11	Activities	32,685	2,926	3,803	39,414		39,414	(3,295)	36,119			11
12	Social Services	59,126	1,459		60,585		60,585		60,585			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	552,470	17,598	24,039	594,107		594,107	3,866	597,973			16
	C. General Administration											
17	Administrative	56,265		3,000	59,265		59,265	5,403	64,668			17
18	Directors Fees											18
19	Professional Services			122,681	122,681		122,681	(96,962)	25,719			19
20	Dues, Fees, Subscriptions & Promotions			6,433	6,433		6,433	(1,595)	4,838			20
21	Clerical & General Office Expenses	38,289	4,906	28,599	71,794		71,794	28,326	100,120			21
22	Employee Benefits & Payroll Taxes			116,499	116,499		116,499		116,499			22
23	Inservice Training & Education			1,045	1,045		1,045	234	1,279			23
24	Travel and Seminar			357	357		357	6,173	6,530			24
25	Other Admin. Staff Transportation			4,184	4,184		4,184	3,504	7,688			25
26	Insurance-Prop.Liab.Malpractice			97,000	97,000		97,000	424	97,424			26
27	Other (specify):*			9,801	9,801		9,801	(425)	9,376			27
28	**TOTAL General Administration**	94,554	4,906	389,599	489,059		489,059	(54,918)	434,141			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	810,383	132,120	474,215	1,416,718		1,416,718	(52,749)	1,363,969			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: SPRINGFIELD TERRACE **#0032961** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	3,680	
	REPAIRS & MAINTENANCE		0	
			0	3,680
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		7,562	
	ELECTRICITY		18,519	
	WATER		7,934	
	CABLE TV - LOBBY		780	
			0	34,795
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		765	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE CONSULTANT		9,962	
	EQUIPMENT MAINTENANCE & REPAIR		0	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		4,939	
			0	
			0	
			0	15,666
7	**OTHER**			
	SCAVENGER		6,026	
	SECURITY SERVICE		410	6,436
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	14,500	14,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	3,795	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	560	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	600	
			0	
			0	4,955
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		232	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	375	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	174	781
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,803	
			0	3,803
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number SPRINGFIELD TERRACE **#0032961** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	3,000	3,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	7,623	
	ADMINISTRATIVE CONSULTANTS	XIX C	7,310	
	PROFESSIONAL FEES	XIX C	16,714	
	BOOKKEEPING/ADMINIST. SERVICE		91,034	122,681
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	886	
	EMPLOYEE WANT ADS	XIX F	1,427	
	CONTRIBUTIONS	VI 20 XIX F	180	
	DUES & SUBSCRIPTIONS	XIX F	2,372	
	LICENSES & PERMITS	XIX F	328	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	856	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	384	6,433
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,150	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	10,142	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		16,638	
	MESSENGER SERVICE		669	
			0	28,599

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	62,265	
	UNEMPLOYMENT COMPENSATION	XIX D	22,919	
	WORKERS COMPENSATION INSURANCI	XIX D	24,400	
	HOSPITALIZATION INSURANCE	XIX D	5,333	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,582	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	116,499
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,045	1,045
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	357	
			0	
			0	357
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,184	4,184
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		97,000	97,000
27	**OTHER**			
	BAD DEBTS	VI 24	9,801	
			0	9,801

GRAND TOTAL COLUMN 3 OTHER 474,215

Facility Name & ID Number SPRINGFIELD TERRACE #0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			5,110	5,110		5,110	20,831	25,941			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,269	14,269		14,269	102,558	116,827			32
33	Real Estate Taxes			14,055	14,055		14,055		14,055			33
34	Rent-Facility & Grounds			128,134	128,134		128,134	(123,425)	4,709			34
35	Rent-Equipment & Vehicles			4,810	4,810		4,810	4,779	9,589			35
36	Other (specify):*											36
37	**TOTAL Ownership**			166,378	166,378		166,378	4,743	171,121			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,587	35,587		35,587		35,587			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			35,587	35,587		35,587		35,587			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	810,383	132,120	676,180	1,618,683		1,618,683	(48,006)	1,570,677			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,817	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(522)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(10,142)	21		18
19	Entertainment		20		19
20	Contributions	(1,036)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,801)	27		24
25	Fund Raising, Advertising and Promotional	(886)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	595			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (19,975)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(28,031)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (28,031)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (48,006)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SPRINGFIELD TERRACE

ID# 0032961

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 595	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	595		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(522)	0	0	0	0	0	0	0	0	0	0	(522)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,273	0	0	0	0	0	0	0	0	0	1,273	5
6	Maintenance	595	(3,110)	0	0	0	0	0	0	0	0	0	(2,515)	6
7	Other (specify):*	0	67	0	0	0	0	0	0	0	0	0	67	7
8	**TOTAL General Services**	73	(1,770)	0	0	0	0	0	0	0	0	0	(1,697)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	7,161	0	0	0	0	0	0	0	0	0	7,161	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	(3,295)	0	0	0	0	0	0	0	0	0	(3,295)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	3,866	0	0	0	0	0	0	0	0	0	3,866	16
	C. General Administration													
17	Administrative	0	5,403	0	0	0	0	0	0	0	0	0	5,403	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(96,962)	0	0	0	0	0	0	0	0	0	(96,962)	19
20	Fees, Subscriptions & Promotions	(1,922)	327	0	0	0	0	0	0	0	0	0	(1,595)	20
21	Clerical & General Office Expenses	(10,142)	0	38,468	0	0	0	0	0	0	0	0	28,326	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	234	0	0	0	0	0	0	0	0	234	23
24	Travel and Seminar	0	0	6,173	0	0	0	0	0	0	0	0	6,173	24
25	Other Admin. Staff Transportation	0	0	3,504	0	0	0	0	0	0	0	0	3,504	25
26	Insurance-Prop.Liab.Malpractice	0	0	424	0	0	0	0	0	0	0	0	424	26
27	Other (specify):*	(9,801)	0	9,376	0	0	0	0	0	0	0	0	(425)	27
28	**TOTAL General Administration**	(21,865)	(91,232)	58,179	0	0	0	0	0	0	0	0	(54,918)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(21,792)	(89,136)	58,179	0	0	0	0	0	0	0	0	(52,749)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,817	0	305	18,709	0	0	0	0	0	0	0	20,831	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	80	102,478	0	0	0	0	0	0	0	102,558	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	4,709	(128,134)	0	0	0	0	0	0	0	(123,425)	34
35	Rent-Equipment & Vehicles	0	0	4,779	0	0	0	0	0	0	0	0	4,779	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,817	0	9,873	(6,947)	0	0	0	0	0	0	0	4,743	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(19,975)	(89,136)	68,052	(6,947)	0	0	0	0	0	0	0	(48,006)	45

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST		ARC OF JACKSONVILLE	JACKSONVILLE	MAVIN	SKOKIE, IL	COUNSULTING,
		LITCHFIELD TERRACE	LITCHFIELD	ENTERPRISES, LTD.		BOOKKEEPING
		RIVER VIEW MANOR	LOVES PARK			
		PARKVIEW TERRACE	EAST MOLINE	IDEA ASSOCIATES	SKOKIE, IL	REAL ESTATE
		GOLDEN MOMENTS	JACKSONVILLE			
		VANDALIA TERRACE	VANDALIA			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	MAINTENANCE CONSULTAN	$ 9,962			$	$ (9,962)	1
2	V	10	PSYCHO-SOCIAL CONSULTANT	3,075				(3,075)	2
3	V	11	ACTIVITIES CONSULTANT	3,295				(3,295)	3
4	V	19	ADMIN. /BKKP. FEES	91,034				(91,034)	4
5	V	19	ADMIN. /CONSULT. FEES	7,310				(7,310)	5
6	V								6
7	V	5	ELECTRICITY/GAS				1,273	1,273	7
8	V	6	MAINTENANCE				6,852	6,852	8
9	V	7	SCAVENGER				67	67	9
10	V	10	PSYCH-SOCIAL & NURSING CONSULT				10,236	10,236	10
11	V	17	ADMINISTRATIVE SALARIES				5,403	5,403	11
12	V	19	PROFESSIONAL FEES				1,382	1,382	12
13	V	20	ADVERTISING				327	327	13
14	Total			$ 114,676			$ 25,540	$ * (89,136)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	TOTAL OFFICE	$	MAVIN ENTERPRISES, LTD.		$ 38,468	$ 38,468	15
16	V	23	SEMINARS				234	234	16
17	V	24	TRAVEL				6,173	6,173	17
18	V	25	TRANSPORTATION				3,504	3,504	18
19	V	27	EMPLOYEE BENEFITS				9,376	9,376	19
20	V	30	DEPRECIATION (SL)				305	305	20
21	V	32	INTEREST				80	80	21
22	V	34	OFFICE RENT				4,709	4,709	22
23	V	35	EQUIPMENT RENT				4,779	4,779	23
24	V	26	INSURANCE				424	424	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 68,052	$ * 68,052	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 128,134	IDEA ASSOCIATES		$	$ (128,134)	15
16	V	30	DEPRECIATION				18,709	18,709	16
17	V	32	INTEREST				102,478	102,478	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 128,134			$ 121,187	$ * (6,947)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6			SEE ATTACHED LIST								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAVIN ENTERPRISES, LTD.
Street Address: 3845 OAKTON
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-0100
Fax Number: (847) 679-0647

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	ELECTRICITY/GAS	PATIENT DAYS	141,473	7	$ 9,514	$	18,927	$ 1,273	1
2	6	MAINTENANCE	PATIENT DAYS	141,473	7	51,216	50,100	18,927	6,852	2
3	7	SCAVENGER	PATIENT DAYS	141,473	7	500		18,927	67	3
4	10	PSYCH-SOCIAL & NURSING	PATIENT DAYS	141,473	7	76,511		18,927	10,236	4
5	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	141,473	7	40,388	40,388	18,927	5,403	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	141,473	7	10,333		18,927	1,382	6
7	20	ADVERTISING	PATIENT DAYS	141,473	7	2,442		18,927	327	7
8	21	TOTAL OFFICE	PATIENT DAYS	141,473	7	287,536	218,675	18,927	38,468	8
9	23	SEMINARS	PATIENT DAYS	141,473	7	1,750		18,927	234	9
10	24	TRAVEL	PATIENT DAYS	141,473	7	46,140		18,927	6,173	10
11	25	TRANSPORTATION	PATIENT DAYS	141,473	7	26,191		18,927	3,504	11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	141,473	7	70,083		18,927	9,376	12
13	30	DEPRECIATION (SL)	PATIENT DAYS	141,473	7	2,285		18,927	305	13
14	32	INTEREST	PATIENT DAYS	141,473	7	601		18,927	80	14
15	34	OFFICE RENT	PATIENT DAYS	141,473	7	35,195		18,927	4,709	15
16	35	EQUIPMENT RENT	PATIENT DAYS	141,473	7	35,725		18,927	4,779	16
17	26	INSURANCE	PATIENT DAYS	141,473	7	3,172		18,927	424	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 699,582	$ 309,163		$ 93,592	25

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY						$	$			$	1
2	IDEA ASSOCIATES											2
3	BANK FINANCIAL		X	MORTGAGE	DEMAND	10/98	874,500	838,214			102,478	3
4												4
5	MGMT CO ALLOCATION										80	5
	Working Capital											
6	BANK FINANCIAL		X	LINE OF CREDIT	DEMAND	11/97	150,000				10,782	6
7	A.I.CREDIT CORPORATION		X	INSURANCE FINANCIAL							3,487	7
8												8
9	TOTAL Facility Related						$ 1,024,500	$ 838,214			$ 116,827	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,024,500	$ 838,214			$ 116,827	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 13,434	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 13,676	2
3. Under or (over) accrual (line 2 minus line 1).		$ 242	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 13,813	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 14,055	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	12,374	8
	1999	13,008	9
	2000	13,073	10
	2001	13,434	11
	2002	13,676	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SPRINGFIELD TERRACE COUNTY SANGAMON

FACILITY IDPH LICENSE NUMBER 0032961

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-35-0-157-019	NURSING HOME	$ 13,676.22	$ 13,676.22
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 13,676.22	$ 13,676.22

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1987	$ 22,340	1
2					2
3	TOTALS			$ 22,340	3

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	65		1987		$ 589,342	$ 18,709	31.5	$ 18,709	$	$ 246,836	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1991	3,905	124	20	196	72	2,328	9
10	VARIOUS			1992	8,184	260	20	409	149	4,341	10
11	VARIOUS			1993	750	19	20	38	19	345	11
12	VARIOUS			1994	540	13	20	27	14	257	12
13	DOOR			1997	1,086	27	20	54	27	347	13
14	SPRINKLER			1997	3,790	97	20	189	92	1,213	14
15	DECORATING			1997	2,281	58	20	114	56	741	15
16	EXHAUST SYTEM			1997	1,250	32	20	62	30	419	16
17	TILE			1997	1,944	49	20	97	48	679	17
18	TILE			1997	638	16	20	32	16	203	18
19	DOORS			1997	1,327	35	20	66	31	407	19
20	SPRINKLER			1997	705	18	20	35	17	219	20
21	SPRINKLER			1997	1,532	40	20	77	37	479	21
22	REWIRE & REPLACE SECURITY			1997	3,000	77	20	150	73	913	22
23	SPRINKLER			1998	2,138	56	20	107	51	588	23
24	DOORS			1998	1,896	49	20	95	46	522	24
25	SECURITY SYSTEM			1998	1,149	30	20	57	27	342	25
26	FLOOR TILE, LIGHTS			1999	1,468	38	20	73	35	365	26
27	SHINGLE ROOF			2000	26,800	974	27.5	974		3,718	27
28	NEW AIR CONDITIONERS			2000	2,255	82	27.5	82		313	28
29	FRONT DOOR WITH LOCK			2000	1,245	46	27.5	46		175	29
30	REPLACE 3 TON CONDENSING UNIT FOR LUNCH ROOM			2001	3,494	127	27.5	127		318	30
31	GUTTERS AND DOWNSPOUTS			2001	2,654	97	27.5	97		242	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
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63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 663,373	$ 21,073		$ 21,913	$ 840	$ 266,310	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 73,053	$ 2,746	$ 2,636	$ (110)	5-10	$ 61,027	71
72	Current Year Purchases					10		72
73	Fully Depreciated Assets							73
74	MGMT CO ALLOCATION		305	305				74
75	TOTALS	$ 73,053	$ 3,051	$ 2,941	$ (110)		$ 61,027	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1998 CHEVROLET VAN	1999	$ 5,429	$	$ 1,087	$ 1,087	5	$ 5,429	76
77										77
78										78
79										79
80	TOTALS			$ 5,429	$	$ 1,087	$ 1,087		$ 5,429	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 764,195	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 24,124	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 25,941	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,817	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 332,766	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 4,810 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs				N/A			7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (28,682)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	313,591		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	127,963		6
7	Other Prepaid Expenses	14,631		7
8	Accounts Receivable (owners or related parties)	97,348		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 524,851	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	74,031		15
16	Equipment, at Historical Cost	78,781		16
17	Accumulated Depreciation (book methods)	(83,694)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 69,118	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 593,969	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 397,919	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	66,726		28
29	Short-Term Notes Payable	725,134		29
30	Accrued Salaries Payable	29,661		30
31	Accrued Taxes Payable (excluding real estate taxes)	33,529		31
32	Accrued Real Estate Taxes(Sch.IX-B)	13,813		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,266,782	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,266,782	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (672,813)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 593,969	$	48

*(See instructions.)

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (445,767)	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	22,740	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (423,027)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(249,786)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (249,786)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (672,813)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	1 Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,368,897	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,368,897	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,368,897	30

	2 Expenses	Amount	
	A. Operating Expenses		
31	General Services	333,552	31
32	Health Care	594,107	32
33	General Administration	489,059	33
	B. Capital Expense		
34	Ownership	166,378	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	35,587	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,618,683	40
41	**Income before Income Taxes (line 30 minus line 40)****	(249,786)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (249,786)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,078	2,153	$ 45,800	$ 21.27	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,804	1,899	34,389	18.11	3
4	Licensed Practical Nurses	7,694	8,138	128,060	15.74	4
5	Nurse Aides & Orderlies	23,182	25,031	219,821	8.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,158	3,414	32,685	9.57	10
11	Social Service Workers	4,108	4,236	59,126	13.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,321	10,932	81,581	7.46	15
16	Dishwashers					16
17	Maintenance Workers	1,656	1,761	16,990	9.65	17
18	Housekeepers	6,347	6,714	42,548	6.34	18
19	Laundry	3,017	3,227	22,240	6.89	19
20	Administrator	1,993	2,243	56,265	25.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,643	5,729	38,289	6.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Care Plen Coord	1,756	1,822	32,589	17.89	33
34	TOTAL (lines 1 - 33)	72,757	77,299	$ 810,383 *	$ 10.48	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 3,680	1-3	35
36	Medical Director	O	14,500	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	600	10-3	38
39	Pharmacist Consultant	H	560	10-3	39
40	Physical Therapy Consultant	L	375	10a-3	40
41	Occupational Therapy Consultant	T	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	174	10a-3	43
44	Activity Consultant	E	3,803	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47	PSYCHO-SOCIAL CONSULTANT		3,795	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 27,487		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses		N/A	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CARLYN CAMINGUE	ADMIN	0	$ 28,133
MARIE BORMIDA	ADMIN	0	25,882
DAVID SERRANO	ADMIN	0	2,250
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 56,265

B. Administrative - Other

Description	Amount
MELVIN SIEGEL	$ 3,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 3,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
NURSING CARE SYSTEMS	DATA PROCESSING	$ 3,670
ALPHA DATA SERVICE	DATA PROCESSING	2,128
LTC SOLUTIONS	DATA PROCESSING	1,320
BEST SOFTWARE	DATA PROCESSING	448
PAULINE HAGEMAN	DATA PROCESSING	57
MAVIN ENTERPRISES LTD	ADMIN. CONSULTANT	7,310
KRUPNICK,BOKOR,KAGDA	ACCOUNTING FEES	10,277
GARY A. WEINTRAUB, P.C.	LEGAL FEES	4,638
LEONARD WEISS	MANAGEMENT CONSUL.	325
PERSONNEL PLANNERS	UC CONSULTANT	1,474
MAVIN ENTERPRISES LTD	BOOKKEEPING/ADMIN	91,034
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 122,681

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 24,400
Unemployment Compensation Insurance		22,919
FICA Taxes		62,265
Employee Health Insurance		5,333
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		1,582
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	1,427
Health Care Worker Background Check	384
(Indicate # of checks performed 28)	
MARKETING/ADV/PROMO	886
TRUST/FRANCHISE/CONTRIB/ETC	1,036
LICENSES & PERMITS	128
DUES & SUBSCRIPTIONS	2,372
MGMT CO ALLOCATION	327
TRUST/FRANCHISE/CONTRIB/ETC	(1,036)
Less: Public Relations Expense	(0)
Non-allowable advertising	(886)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,838

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	357
MGMT CO ALLOCATION	6,173
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,530

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATIN	7/2001	$ 1,785	3 YRS	$	$ 297	$ 595	$ 595	$ 298	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 1,785		$	$ 297	$ 595	$ 595	$ 298	$	$	$	$

Facility Name & ID Number SPRINGFIELD TERRACE # 0032961 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $2367**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **35,587**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees